

RELIANCE STANDARD

Life Insurance Company

Home Office: Chicago, Illinois • Administrative Office: Philadelphia, Pennsylvania

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CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured, for the benefits which apply to your class, under Group Policy No. GL 130938 issued to City of Newport Beach, the Policyholder.

When loss of life covered under the Policy occurs, we will pay the amount stated on the Schedule of Benefits to the named beneficiary, subject to provisions entitled Beneficiary and Facility of Payment.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all certificates that may have been issued to you earlier.


Secretary


President

GROUP LIFE INSURANCE CERTIFICATE

This Group Life Certificate amends all previous Group Life Certificates and is dated August 7, 2006.

SCHEDULE OF BENEFITS

EFFECTIVE DATE: January 1, 2002, as amended in the Policy through July 1, 2006

ELIGIBLE CLASSES: Each active, Full-time employee, except any person employed on a temporary or seasonal basis, according to the following classifications:

CLASS 1: Employee

CLASS 2: City Council Member

INDIVIDUAL EFFECTIVE DATE: The day you become eligible.

AMOUNT OF INSURANCE:

Basic Life:

CLASS 1: One (1) times Earnings, rounded to the next higher \$1,000, subject to a maximum of \$50,000.

CLASS 2: \$5,000.

The Amount of Basic Life Insurance will be reduced by 50% of the pre-age 70 amount at age 70 and terminates at retirement.

The Life amount will be reduced by any benefit paid under the Accelerated Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE: Changes in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the date of the change, provided you are Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of the Basic Insurance.

DEFINITIONS

"We," "us" and "our" means Reliance Standard Life Insurance Company.

"You," "your" and "yours" means a person who meets the eligibility requirements of the Policy and is enrolled for this insurance.

"Actively at work" and "active work" means actually performing on a Full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of injury or illness.

CLASS 1: "Full-time" means working for the Policyholder for a minimum of 40 hours during your regularly scheduled work week.

"The date you retire" or "retirement" means the effective date of your:

- (1) retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
- (2) retirement pension benefits under any plan which the Policyholder sponsors, or makes or has made contributions;
- (3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

CLASS 1: "Earnings", as used in the SCHEDULE OF BENEFITS section, means your annual salary received from the Policyholder on the day just before the date of loss. Earnings do not include commissions, overtime pay, bonuses or any other special compensation not received as basic salary.

If hourly employees are insured, the number of hours worked during a regularly scheduled work week, not to exceed forty (40) hours per week, times fifty-two (52) weeks, will be used to determine annual earnings.

"Total Disability" as used in the WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY section, means your complete inability to engage in any type of work for wage or profit for which you are suited by education, training or experience.

GENERAL PROVISIONS

INCONTESTABILITY

Any statements made by you, or on your behalf to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which you are covered. The following rules apply to each statement:

- (1) No statement will be used in a contest unless:
 - (a) it is in a written form signed by you, or on your behalf; and
 - (b) a copy of such written instrument is or has been furnished to you, your beneficiary or legal representative.
- (2) If the statement relates to your insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two (2) years during your lifetime.

ASSIGNMENT

Ownership of any benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

EFFECTIVE DATE AND TERMINATION

EFFECTIVE DATE OF INSURANCE: If the Policyholder pays the entire premium, your insurance will go into effect on the date stated on the Schedule of Benefits. If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the date stated on the Schedule of Benefits, except that the insurance will go into effect:

- (1) on the date you apply, if you apply within thirty-one (31) days of the date you are first eligible; or
- (2) on the date we approve any required proof of good health. We require proof of good health if you apply:
 - (a) after thirty-one (31) days from the date you first become eligible; or
 - (b) after you terminated this insurance but remained in a class eligible for this insurance.

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

If you are not actively at work on the day your insurance is to go into effect, the insurance will go into effect on the day you return to active work for one full day.

TERMINATION OF INSURANCE:

CLASS 1: Your insurance will terminate on the first of the following to occur:

- (1) the date the Policy terminates; or
- (2) the date you cease to be in a class eligible for this insurance; or
- (3) the end of the period for which premium has been paid for you; or
- (4) the date you enter military service (not including Reserve or National Guard).

CLASS 2: Your insurance will terminate on the first of the following to occur:

- (1) the date the Policy terminates; or
- (2) the last day of the Policy month in which you cease to be in a class eligible for this insurance; or
- (3) the end of the period for which premium has been paid for you; or
- (4) the date you enter military service (not including Reserve or National Guard).

CONTINUATION OF INSURANCE: Your insurance may be continued by payment of premium beyond the date you cease to be eligible for this insurance, but not longer than:

- (1) twelve (12) months, if due to illness or injury; or
- (2) one (1) month, if due to temporary lay-off or approved leave of absence.

CONVERSION PRIVILEGE

You can use this privilege when your insurance is no longer in force. It has several parts. They are:

- A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:
 - (1) The policy will, at your option, be on any one of our forms, except for term life insurance. It will be the standard type issued by us for the age and amount applied for;
 - (2) The policy issued will be for an amount not over what you had before you terminated;
 - (3) The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and
 - (4) Proof of good health is not required.
- B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. You must have been insured for at least five (5) years under the Policy. The same rules as in A above will be used, except that the face amount will be the lesser of:
 - (1) The amount of your Group Life benefit under the Policy. This amount will be less any amount you are entitled to under any group life policy issued by us or another insurance company; or
 - (2) \$5,000.
- C. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.
- D. If you die during the time in which you are entitled to apply for an individual policy, we will pay the benefit under the Group Policy that you were entitled to convert. This will be done whether or not you applied for the individual policy.
- E. Any policy issued with respect to A, B or C above will be put in force at the end of the thirty-one (31) day period in which application must be made.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: The beneficiary will be as named in writing by you to receive benefits at your death. This beneficiary designation must be on file with us or the Plan Administrator and will be effective on the date you sign it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

If you name more than one beneficiary to share the benefit, you must state the percentage of the benefit that is to be paid to each beneficiary. Otherwise, they will share the benefit equally.

The beneficiary's consent is not needed if you wish to change the designation. His/her consent is also not needed to make any changes in the Policy.

If the beneficiary dies at the same time as you, or within fifteen (15) days after your death but before we received written proof of your death, payment will be made as if you survived the beneficiary, unless noted otherwise.

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, any benefits due shall be paid to the first of the following classes to survive you:

- (1) your legal spouse or domestic partner;
- (2) your surviving children (including legally adopted children), in equal shares;
- (3) your surviving parents, in equal shares;
- (4) your surviving siblings, in equal shares; or, if none of the above,
- (5) your estate.

We will not be liable for any payment we have made in good faith.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed \$1,000.

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to \$2,500 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with your last illness, death or burial.

The balance of the benefit, if any, will be held by us, until an individual or representative:

- (1) is validly named; or
- (2) is appointed to receive the proceeds; and
- (3) can give valid release to us.

The benefit will be held with interest at a rate set by us.

We will not be liable for any payment we have made in good faith.

SETTLEMENT OPTIONS

You may elect a different way in which payment of the Amount of Insurance can be made. You must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under \$2,000 or option payments of less than \$20.00 each are not eligible.

If no instructions for a settlement option are in effect at your death, the beneficiary may make the election, with our consent.

Settlement Options are described in the Policy.

WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

We will extend the Amount of Insurance during a period of Total Disability for one (1) year if:

- (1) you become totally disabled prior to age 60;
- (2) the Total Disability begins while you are insured;
- (3) the Total Disability begins while the Policy is in force;
- (4) the Total Disability lasts for at least 6 months;
- (5) the premium continues to be paid; and
- (6) we receive proof of Total Disability within one (1) year from the date it began.

After proof of Total Disability is approved by us, neither you or the Policyholder is required to pay premiums. Also, any premiums paid from the start of the Total Disability will be returned.

We will ask you to submit annual proof of continued Total Disability. The Amount of Insurance may then be extended for additional one (1) year periods. You may be required to be examined by a Physician approved by us as part of the proof. We will not require you to be examined more than once a year after the insurance has been extended two (2) full years.

The Amount of Insurance extended will be limited to the amount of basic group life coverage on your life that was in force at the time that Total Disability began excluding any additional benefits. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if you had not been totally disabled. If you die, we will be liable under this extension only if written proof of death is received by us.

The Amount of Insurance extended for you will cease on the earliest of:

- (1) the date you no longer meet the definition of Total Disability; or
- (2) the date you refuse to be examined; or
- (3) the date you fail to furnish the required proof of Total Disability; or
- (4) the date you become age 70; or
- (5) the date you retire.

You may use the conversion privilege when this extension ceases. Please refer to the Conversion Privilege section for rules. You are not entitled to conversion if you return to work and are again eligible for the insurance under the Policy. If you use the conversion privilege, benefits will not be payable under the Waiver of Premium in Event of Total Disability provision unless the converted policy is surrendered to us.

If you qualify for benefits in accordance with the Waiver of Premium in Event of Total Disability provision because you have been diagnosed by a Physician as totally disabled due to the following Condition(s) or Procedure(s), as later defined;

- (1) Life Threatening Cancer; or
- (2) Heart Attack (Myocardial Infarction); or
- (3) Kidney (Renal) Failure; or
- (4) Receipt of Major Organ Transplant; or
- (5) Stroke,

we will pay you an additional, one time, lump sum benefit in an amount equal to 10% of the death benefit under the basic life portion of this Policy up to a maximum of \$100,000.

This lump sum benefit applies only to the first Condition or Procedure to occur among those hereinafter defined which qualifies you for waiver of premium benefits. No further lump sum benefits will be payable under this provision during the same or any subsequent periods of Total Disability, or as a result of the occurrence of any other Condition or Procedure.

Definition(s):

“Condition(s) or Procedure(s)” mean only the following:

“Life Threatening Cancer” means a malignant neoplasm (including hematologic malignancy), as diagnosed by a Physician who is a board certified oncologist, and which is characterized by the uncontrolled growth and spread of

malignant cells and the invasion of tissue, and which is not specifically excluded. The following types of cancer are not considered a Life Threatening Cancer: (1) early prostate cancer diagnosed as T2c or less according to the TNM scale; (2) colorectal cancer diagnosed as T2, N1, M0 or less according to the TNM scale; (3) breast cancer diagnosed as T3, N2, M0 or less according to the TNM scale; (4) First Carcinoma in Situ; (5) pre-malignant lesions (such as intraepithelial neoplasia); (6) brain glioma; (7) benign tumors or polyps; (8) tumors in the presence of the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS); or (9) any skin cancer other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become Life Threatening Cancers.

“First Carcinoma in Situ” means the first diagnosis of cancer in which the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue. First Carcinoma in Situ must be diagnosed pursuant to a pathological diagnosis or clinical diagnosis.

“Heart Attack (Myocardial Infarction)” means the death of a segment of the heart muscle as a result of a blockage of one or more coronary arteries. In order to be covered under this provision, the diagnosis by a Physician of Heart Attack (Myocardial Infarction) must be based on:

- (1) new electrocardiographic changes consistent with and supporting a diagnosis of Heart Attack (Myocardial Infarction); and
- (2) a concurrent diagnostic elevation of cardiac enzymes; and
- (3) therapeutic and functional classifications, 3 or above and C or above respectively, according to the New York Heart Association.

“Kidney (Renal) Failure” means the chronic irreversible failure of both of the kidneys (end stage renal disease), which requires treatment with dialysis on a regular basis. Kidney Failure is covered under this provision only if the diagnosis has been made by a Physician who is a board certified nephrologist.

“Physician” means a duly licensed practitioner who is recognized by the law of the jurisdiction in which treatment is received as qualified to treat the type of condition for which claim is made. The Physician may not be you or a member of your immediate family and must be approved by us.

“Receipt of Major Organ Transplant” means that you have been the recipient of a major organ transplant and that there is clinical evidence of major organ(s) failure which, according to the diagnosis of a Physician, required your failing organ(s) or tissue to be replaced with organ(s) or tissue from a suitable donor under generally accepted medical procedures. Organs or tissues covered by this definition are limited to liver, kidney, lung, entire heart, pancreas, or pancreas-kidney.

“Stroke” means a cerebrovascular accident or infarction (death) of brain tissue, as diagnosed by a Physician, which is caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least one hundred eighty (180) days following the occurrence of the Stroke. Stroke does not include Transient Ischemic Attack (TIA) or other cerebral vascular events.

Receipt of this additional lump sum payment may be taxable. You should seek assistance from your own personal tax advisor.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include your name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: Payment will be made as soon as proper proof is received. All benefits will be paid to you, if living. Any benefits unpaid at the time of death, or due to death, will be paid to the beneficiary.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION: At our own expense, we will have the right to have you examined as reasonably necessary when a claim is pending. We can have an autopsy made unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina, six (6) years) from the time written proof of loss is required to be submitted.

FAMILY AND MEDICAL LEAVE OF ABSENCE EXTENSION

We will allow your coverage to continue for up to 12 weeks in a 12 month period, if you are eligible for, and the Policyholder has approved, a Family and Medical Leave of Absence under the terms of the Family and Medical Leave Act of 1993 or the California Family Rights Act of 1992, as amended, for any of the following reasons:

- (1) to provide care after the birth of a son or daughter; or
- (2) to provide care for a son or daughter upon legal adoption; or
- (3) to provide care after the placement of a foster child in your home; or
- (4) to provide care to a spouse, son, daughter, or parent due to serious illness; or
- (5) to take care of (a) your own serious health condition under the terms of the Family and Medical Leave Act of 1993; or (b) your own serious health condition except for pregnancy, childbirth or related medical conditions, under the terms of the California Family Rights Act of 1992, as amended.

We will also allow your coverage to continue, if you are eligible for and the Policyholder has approved a leave of absence in accordance with the terms of the pregnancy disability laws under California's Fair Employment and Housing Act, as amended, under the following circumstances:

- (1) to take care of your own health due to normal pregnancy, childbirth or medical condition related to such normal pregnancy for a period not to exceed six (6) weeks; or
- (2) to take care of your own serious health condition when disabled due to pregnancy, childbirth or related medical conditions not to exceed four (4) months.

If you, due to your own serious health condition, meet the definition of Total Disability in the Policy, you will be considered Totally Disabled and eligible for Waiver of Premium benefits according to the Waiver of Premium in Event of Total Disability provision. If you, due to your own serious health condition, are on a Family and Medical Leave of Absence, but not eligible for Waiver of Premium benefits under the Policy, insurance coverage will be continued under this extension.

You will not qualify for the Family and Medical Leave of Absence Extension unless we have received proof from the Policyholder, in a form satisfactory to us, that you have been granted a leave under the terms of the Family and Medical Leave Act of 1993, the California Family Rights Act of 1992, as amended, or the Fair Employment and Housing Act, as amended. Such proof: (1) must outline the terms of your leave; and (2) give the date the leave began; and (3) the date it is expected to end; and (4) must be received by us within thirty-one (31) days after a claim for benefits has been filed with us.

If the Policyholder grants you a Family and Medical Leave of Absence, the following applies to you:

- (1) While you are on an approved Family and Medical Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force.
- (2) Coverage will terminate for you if you do not return to work as scheduled according to the terms of your agreement with the Policyholder; however, you are eligible to convert your coverage under the Conversion Privilege. In no case will coverage be extended under this benefit beyond 12 weeks in a 12 month period. Insurance will not be terminated for you if you become Totally Disabled during the period of the leave and are eligible for Waiver of Premium benefits, if any, according to the terms of the Policy.
- (3) This extension is not available if you convert your coverage under the Conversion Privilege.
- (4) While you are on an approved Family and Medical Leave of Absence, you will be considered Actively at Work in all instances unless such leave is due to your own illness, injury, or disability. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you while you are not Actively at Work until such time you return to Active Work for one full day.

All other terms and conditions of the Policy will remain in force while you are on an approved Family and Medical Leave of Absence.

MILITARY SERVICES LEAVE OF ABSENCE COVERAGE

We will allow your coverage to continue for up to twelve (12) weeks in a twelve (12) month period, if you enter the military service of the United States. While you are on a Military Services Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you until you have returned to work from Military Services Leave of Absence for one full day. All other terms and conditions of the Policy will remain in force during this continuation period. Your continued coverage will cease on the earliest of the following dates:

- (1) the date the Policy terminates; or
- (2) the date ending the last period for which any required premium was paid; or
- (3) twelve (12) weeks from the date your continued coverage began.

The Policy, however, does not cover any loss which occurs while you are on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared).

GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. INSURED SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.

THIS ACCELERATED BENEFIT IS NOT INTENDED TO BE USED AS LONG TERM CARE INSURANCE. BENEFIT PAYMENTS MAY EFFECT QUALIFICATIONS FOR GOVERNMENT ENTITLEMENT PROGRAMS SUCH AS MEDICAID.

THIS RIDER DOES NOT CONTAIN ITS OWN WAIVER OF PREMIUM PROVISION. THE WAIVER OF PREMIUM PROVISION, IF ANY, OF THE GROUP LIFE POLICY WILL APPLY.

THE RIGHT TO REQUEST ACCELERATION MAY BE EXERCISED AT THE SOLE OPTION OF THE INSURED. THIS REQUEST MUST BE MADE VOLUNTARILY AND WITHOUT COERCION ON THE PART OF ANY THIRD PARTY. NO HEALTH CARE FACILITY CAN REQUIRE AN INSURED TO ACCELERATE PAYMENT OF THE DEATH BENEFIT AS A CONDITION OF ADMISSION TO SUCH FACILITY OR FOR PROVIDING ANY CARE IN SUCH FACILITY. TO THE EXTENT PERMITTED BY LAW, THE ACCELERATED BENEFIT SHALL NOT BE SUBJECT TO THE CLAIMS OF CREDITORS OR THE LEGAL PROCESS.

Attached to Group Policy Number: GL 130938

Issued to Group Policyholder: City of Newport Beach

This Rider is attached to and made a part of the Policy indicated above. Your Certificate is hereby amended, in consideration of the application for this coverage, by the addition of the following benefit. In this Rider, Reliance Standard Life Insurance Company will be referred to as "we", "us", "our".

DEFINITIONS: This section gives the meaning of terms used in this Rider. The Definitions of the Policy and Certificate also apply unless they conflict with Definitions given here.

"Certified" or "Certification" refers to a written statement, made by a Physician on a form provided by us, as to the Insured's Terminal Illness.

"Certificate" means the document, issued to each Insured, which explains the terms of his coverage under the Group Life Insurance Policy.

"Death Benefit" means the insurance amount payable under the Certificate at death of the Insured. It does not include any amount that is only payable in the event of Accidental Death.

"Insured" means only a primary Insured. Dependents are not eligible for coverage under this Accelerated Benefit Rider.

"Physician" means a duly licensed practitioner, acting within the scope of his license, who is recognized by the law of the state in which diagnosis is received. The Physician may not be the Insured or a member of his immediate family.

"Policy" means the Group Life Insurance Policy issued to the Group Policyholder under which the Insured is covered.

"Terminally Ill" or "Terminal Illness" refers to an Insured's illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in less than 12 months.

"Written Request" means a request made, in writing, by the Insured to us.

All pronouns include either gender unless the context indicates otherwise.

DESCRIPTION OF COVERAGE: This benefit is payable to the Insured if, after having been covered under this Rider for at least 60 days, an Insured is Certified as Terminally Ill. In order for this benefit to be paid:

- (1) the Insured must make a Written Request; and
- (2) we must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

We may, at our option, confirm the terminal diagnosis with a second medical exam performed at our own expense. If the second medical exam produces a conflicting diagnoses we would arrange for a third medical exam to be performed at our

own expense. The initial terminal diagnosis would then be honored if it is confirmed by the third opinion.

AMOUNT OF THE ACCELERATED BENEFIT: The Accelerated Benefit will be an amount equal to 50% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of \$250,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by us and the Insured. The Accelerated Benefit is payable one time only for any Insured under this Rider.

EFFECT OF BENEFIT: If an Insured becomes eligible for, and elects to receive this benefit, it will have the following effects:

- (1) The Death Benefit payable for such Insured will be reduced by an amount equal to the Accelerated Benefit paid to such Insured. The amount of the Accelerated Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.
- (2) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.

TERMINATION OF AN INDIVIDUAL'S COVERAGE UNDER THIS RIDER: The coverage of any Insured under this Rider will terminate on the first of the following:

- (1) the date his coverage under the Policy terminates;
- (2) the date of payment of the Accelerated Benefit for his Terminal Illness; or
- (3) the date he attains age 75.

ADDITIONAL PROVISIONS: This Rider takes effect on the Effective Date shown. It will terminate on the date the Group Policy terminates. It is subject to all the terms of the Group Policy not inconsistent herein.

In witness whereof, we have caused this Rider to be signed by our Secretary.


Secretary

NOTICE TO POLICYHOLDERS/INSUREDS

We are here to serve you...

As our policyholder/insured, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

If you are not satisfied...

If you have any questions or complaints about your insurance, please write to our Director of Claims or Department of Consumer Relations at the following address, or call us using our toll-free telephone number.

**Reliance Standard Life Insurance Company
2001 Market Street, Suite 1500
Philadelphia, PA 19103-7090**

Toll-free telephone number: 1-800-644-1103

If, after contacting us, you feel that your problem is not resolved or you are not being treated fairly, you may contact the California Department of Insurance by writing to them at the following address or using their toll-free telephone number.

**Consumer Services Division
State of California
Department of Insurance
300 South Spring Street
South Tower, Suite 201
Los Angeles, CA 90013**

**Toll-free Consumer Hotline in California: 1-800-927-HELP
Area codes 213, 310, and 818 and out-of-state: 1-213-897-8921**

**Claim Procedures and
ERISA Statement of Rights**

**CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELiance STANDARD LIFE INSURANCE COMPANY
ON OR AFTER JANUARY 1, 2002**

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate that the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims

In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims

A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of "ERISA" (where applicable), following an adverse benefit determination on review; and
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and
8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:
 - (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
 - (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable);
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
6. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency" (where applicable).

DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

- A document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information:
- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.